

DELAWARE TOWNSHIP

WORKERS COMPENSATION INSURANCE COVERAGE INFORMATION

BOARD OF SUPERVISORS • 116 Wilson Hill Road • Dingmans Ferry, PA 18328
Phone: 570.828-2347 • Fax: 570-828-8705 • Email:dtbos@ptd.net

A. The applicant is:

A contractor within the meaning of the pennsylvania workers compensation law.

☐ Yes ☐ No

If the answer is "yes", complete sections B and C below, as appropriate.

B. Insurance information:

Name of applicant: _____

Federal or state employer identification no: _____

☐ Applicant is a qualified self-insurer for workers compensation.
Certification attached

Name of workers compensation insurer: _____

Workers compensation insurance policy no.# _____
Certification attached

Policy expiration date: _____

C. Exemption:

Complete Section C if the applicant is a contractor claiming exemption from providing workers compensation insurance.

The undersigned swears or affirms that (s)he is not required to provide workers compensation insurance under the provisions of pennsylvania workers compensation law for one of the following reasons, as indicated:

Contractor with no employees. Contractor prohibited by law from employing any individual to perform work pursuant to this building permit unless contractor provides proof of insurance to township.

☐ Religious exemption under the workers compensation law.

Subscribed and sworn to before me this _____ Day of _____ 20____

Signature of applicant _____

Address _____

County _____ Municipality _____

Signature and seal of notary public

Commission expires: _____